MDR Tracking Number: M5-04-1843-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 2-23-04.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The electrical stimulation, office visits from 7/28/03 through 8/4/03, and office visits dated 9/2/03, 10/13/03, and 11/10/03 **were found** to be medically necessary. The remaining office visits from 8/7/03 through 11/3/03 **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to the electrical stimulation on 9/13/03, and office visits from 7/28/03 through 8/4/03, and office visits dated 9/2/03, 10/13/03, and 11/10/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 10th day of May 2004.

Regina Cleave
Medical Dispute Resolution Officer
Medical Review Division

RC/rc

April 21, 2004

MDR Tracking Number: M5-04-1843-01
IRO Certificate # 5259

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___ or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY

Patient is a 41-year-old male who injured his neck, lower back and right shoulder in an occupational motor vehicle accident on ___. He sought care from a doctor of chiropractic soon after the injury and attempted conservative care, but eventually underwent surgical fusion to his neck in 2002, and then full thickness tear repair of his right rotator cuff in the fall of 2003. His lower back has been symptomatic for the entire time since the injury.

REQUESTED SERVICE (S)

Office visits, expanded, with manipulation (99213). And electrical stimulation for dates of service 07/28/03 through 11/10/03

DECISION

The office visits, extended (99213) from 07/28/03 through 08/04/03 are approved, as are the office visits on 09/02/03, 10/13/03 and 11/10/03. Also, the electrical stimulation is approved.

The remaining office visits are denied.

RATIONALE/BASIS FOR DECISION

While the diagnosis and records submitted in this case support the medical necessity for periodic evaluations (represented by 99213 “office visit, extended problem focused”), they did not support evaluations at this high level of service at every encounter. For this reason, office visits at a frequency of more than one per month after 08/01/03 were not medically necessary. However, prior to 08/01/03, the medical necessity of this service was supported because TWCC medical fee guidelines required doctors of chiropractic who performed manipulative procedures during an office visit to report the service this way for their routine encounters.

The stimulation service (G0283) performed on 09/13/03 was approved because the medical records submitted sufficiently documented a flare up in the patient’s condition.